BlueCross BlueShield of North Carolina

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Corporate Medical Policy

Orthodontics for Pediatric Patients

File Name: orthodontics_for_pediatric_patients
Origination: 2/2014
Last Review: 10/2023

Description of Procedure or Service

Children's dental services are included as part of the Essential Health Benefit (EHB) package under the Patient Protection and Affordable Care Act (PPACA) of 2010. Children in segments of the population where the EHB package is required will have dental coverage offered as part of that package.

Related Policies:
Orthognathic Surgery
Cosmetic and Reconstructive Surgery
Dental Reconstructive Services
Temporomandibular Joint Dysfunction (TMJD)

******Note: This Medical Policy is complex and technical. For questions concerning the technical language and/or specific clinical indications for its use, please consult your physician.***

Policy

BCBSNC will provide coverage for Orthodontics for Pediatric Patients when it is determined to be medically necessary because the medical criteria and guidelines noted below are met.

Benefits Application

This medical policy relates only to the services or supplies described herein. **Please refer to the Member's Benefit Booklet for availability of benefits.** Under the Patient Protection and Affordable Care Act (PPACA) requirements, some medical plans, which would include metallic level, non-grandfathered plans, will cover medically necessary orthodontic services for children and adolescents through age 18, under a pediatric oral health benefit.

This medical policy does NOT apply to orthodontia services related to accidental injury or congenital defects, as orthodontia for those conditions is covered separately on the medical benefit and not under the essential health benefit of pediatric oral health.

This policy does not apply to coverage specified under dental benefits. Please check specific medical plan benefit services and descriptions before applying this medical policy.

Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this medical policy.

When Orthodontics for Pediatric Patients is covered

Orthodontics for Pediatric Patients for treatment of severe malocclusion or dental misalignment may be considered medically necessary for each of the following clinical indications when the medical guidelines and orthodontic Documentation Requirements listed below are both met.

Elements must be met under one of the following: A or B,

A) Treatment of malocclusion that contributes to recalcitrant temporomandibular (TMJ) syndrome symptoms, as defined in Corporate Medical Policy "Temporomandibular Joint Dysfunction (TMJD)"

OR

B) Treatment of malocclusion that contributes significantly to any one of the following (1, 2, or 3)

1) Speech abnormality

Medical necessity criteria should include both of the following:

a. Speech deficit is noticeable to a lay person or primary care physician and significantly impairs the patient's ability to communicate (Disturbance or impairment of sibilant sound class is not considered a significant functional impairment); AND
b. The speech deficit cannot be resolved by speech therapy (requires speech therapy evaluation).

OR

2) Pre- and post-surgical orthodontics as part of a medically necessary treatment plan for orthognathic surgery, according to the guidelines and criteria in Corporate Medical Policy "Orthognathic Surgery;"

OR

3) Significant intraoral trauma while chewing related to malocclusion.
Information should be supplied which indicates the severity and duration of the trauma and the extent of the interruption to daily activities. This may include recurrent damage to the soft tissues of the mouth during mastication, lower incisors injuring the soft tissue of the palate, cheek biting, lip biting, impingement or irritation of buccal or lingual soft tissues of the opposing arch. The injury or damage to soft tissues must be documented by objective findings in the medical record and supported by photos.

Documentation Requirements

1. The provider must establish medical necessity of pediatric orthodontics to support severe malocclusion and the presence of one of the following qualifying medical conditions:
    a. recalcitrant temporomandibular (TMJ) syndrome symptoms;
    b. speech abnormality;
    c. malnutrition related to choking, difficulty swallowing, or an inability to masticate; or
    d. significant intraoral trauma while chewing.
2. A written report from the attending pediatrician or qualified medical specialist treating the member is recommended when necessary to establish the severity of the medical condition.
3. Orthodontic records to include all of the following:
    a. Cephalometric headfilm or cone beam CT (CBCT) generated diagrams with standard computer generated measurements
    b. Extraoral and intraoral photos
    c. Panoramic film
    d. Models should be performed, but should not be mailed or shipped to BCBS NC for review.

   e. Any other necessary records to provide a complete diagnosis.
4. Severe malocclusion or dental misalignment is characterized by at least **one of the following:**
   a. for patients with mandibular excess or maxillary deficiency, a reverse overjet (ROJ) of at least 3mm;
   b. for patients with maxillary excess or mandibular deficiency, an overjet (OJ) of at least 6mm;
   c. anterior open bite (OB) of at least 4mm;
   d. posterior open bite (OB) (not involving partially erupted teeth) of 2mm;
   e. overbite that is deep (of at least 7mm), complete, and demonstrates intraoral trauma;
   f. posterior transverse discrepancies that involve several posterior teeth in crossbite, one of which must be a molar;
   g. anterior crossbite, where there are malposed labiolingual relations between one or more maxillary and mandibular anterior teeth;
   h. crowding greater than 6 mm in either arch;
   i. excessive anterior spacing of 8 mm or greater;
   j. impacted teeth;
   k. missing teeth.
5. Orthodontic plan of care or contract, which indicates when the initial placement of the appliances will take place, and how many months the adjustments are planned.

When Orthodontics for Pediatric Patients is not covered

The following are considered **not medically necessary** and are not covered:

- Pediatric orthodontics performed primarily for cosmetic purposes.
- Pediatric orthodontics performed for malocclusion when the criteria listed above and when requirements in the Policy Guidelines below are not met.

Policy Guidelines

Orthodontic treatment is not considered medically necessary for dental conditions that are primarily cosmetic in nature. The presence of malocclusion alone does not qualify for orthodontic coverage without a demonstrated severe functional impairment. Although orthodontics may be advisable from a dental standpoint for malocclusion, nevertheless it is not a covered medical benefit unless there is documentation based on medical records over time by treating medical physicians that the malocclusion is affecting the patient's PHYSICAL health, not just dental health.

All pediatric orthodontic coverage for metallic level, non-grandfathered products requires prior review.

Covered Services

When Orthodontics for Pediatric Patients is considered medically necessary, the following are **covered services** and considered part of comprehensive orthodontic care:

- Diagnosis, including the examination, study models, x-rays, and other aids needed to define the problem
- Appliance, a device worn during the course of treatment. Coverage includes the design, making, placement and adjustment of the device. Benefits are not provided to repair or replace an appliance.
- Treatment may include Phase I or Phase II treatment.

Phase I treatment is limited orthodontic treatment and can be paid in one total fee when treatment begins. Phase II treatment is comprehensive orthodontics and is divided into multiple payments.

Definitions

Malnutrition is the condition that develops when the body does not get the right amount of the vitamins, minerals, and other nutrients it needs to maintain healthy tissues and organ function.

Intra-Arch Deviations:

- Crowded refers to tooth irregularities that interrupt the continuity of the dental arch when the space is insufficient for alignment without moving other teeth in the arch. Crowded teeth may or may not also be rotated.
- Rotated refers to tooth irregularities that interrupt the continuity of the dental arch but there is sufficient space for alignment.
- Open spacing refers to tooth separation that exposes to view the interdental papillae.
- Closed spacing refers to partial space closure that will not permit a tooth to complete its eruption without moving other teeth in the same arch.
- Intra-arch deviations may occur in the either the anterior or posterior segment.

Inter-Arch Deviations:

- Overjet is the horizontal projection of maxillary teeth beyond the mandibular teeth, usually measured parallel to the occlusal plane.
- Overbite is the extension of the upper incisor teeth over the lower ones vertically when the opposing posterior teeth are in contact.
- Cross-bite may occur in the anterior or posterior segment. Posterior crossbite is defined as a malocclusion in the canine, premolar, and molar regions, characterized by the buccal cusps of the maxillary teeth occluding lingual to the buccal cusps of the corresponding mandibular teeth. It can also be a buccal crossbite where the lingual cusps of the maxillary teeth are positioned buccal to the buccal cusps of the mandibular teeth. There is no effective contact of teeth. This is called a buccal crossbite or a Brody bite. Anterior crossbite is defined as malposed labiolingual relations between one or more maxillary and mandibular anterior teeth.
- Open-bite may occur in the anterior or posterior segment. Anterior open-bite refers to vertical inter-arch dental separation between the upper and lower teeth when the posterior teeth are in terminal occlusion. Posterior open bite refers to the failure of the posterior teeth to occlude, unilaterally or bilaterally, when the anterior teeth are in occlusion.
- Anteroposterior deviation refers to the occlusion forward or rearward of the accepted normal of the mandibular canine, first and second premolars, and first molar in relation to the opposing maxillary teeth.

Billing/Coding/Physician Documentation Information

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Applicable codes: *D8010, D8020, D8030, D8040, D8050, D8060, D8070, D8080, D8090, D8210, D8220, D8660, D8670, D8680, D8999*

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

Scientific Background and Reference Sources

http://www.ncdhhs.gov/dma/mp/2ortho.pdf

http://www.hhs.gov/healthcare/rights/law/patient-protection.pdf Section 748 pages 1325-1326.

https://www.dominiondental.com/files/Dentist_Forms/Other_Forms/salzmann_evaluation_index.pdf

Senior medical director review 9/2014

Specialty Matched Consultant Advisory Panel 10/2015

Medical Director Review 10/2015

Specialty Matched Consultant Advisory Panel 10/2020

Medical Director Review 10/2021

Specialty Matched Consultant Advisory Panel 10/2021

Medical Director Review 10/2022

Specialty Matched Consultant Advisory Panel 10/2022

Medical Director Review 10/2023

Specialty Matched Consultant Advisory Panel 10/2023

Policy Implementation/Update Information

9/30/14 New medical policy issued. BCBSNC will provide coverage for Orthodontics for Pediatric Patients when it is determined to be medically necessary because the medical criteria and guidelines are met. Notification given 9/30/2014 for effective date 1/1/2015. Senior Medical director review 9/2014. (lpr)

11/25/14 Under "When Covered" added missing teeth and impacted teeth to the orthodontic criteria. Moved Documentation Requirements to "When Covered" section from Policy Guidelines. Under "When Covered" section specified that both medical and orthodontic criteria must be met. Under Documentation Requirements #2, changed requirement to recommended when necessary. Under "When Covered" section Documentation Recommendations #4-moved deep bite over 7 mm from c. to e. and added "maxillary excess" to b. Senior medical director review 11/2014.Remains on 90 day notice for effective date 1/1/2015. (lpr)

12/30/14 Corrected spelling of malposed in "when covered" and Policy Guidelines sections. Simplified definition of overjet and overbite under Inter-Arch Deviations in Policy Guidelines section: prior statements= Overjet refers to labial axial inclination of the maxillary incisors in relation to the mandibular incisor, permitting the latter to occlude on or over the palatal mucosa; Overbite refers to the occlusion of the maxillary incisors on or over the labial gingival mucosa of the mandibular incisors, while the mandibular incisors themselves occlude on or over the palatal mucosa in back of the maxillary incisors. Policy effective 1/1/2015. (lpr)

12/30/15 Specialty Matched Consultant Advisory Panel review 10/29/2015. Medical Director Review 10/2015. (td)

11/22/16 Effective 1/1/2017, a 12 month waiting period no longer applies. Revised the definition of "crossbite" in the Policy Guidelines section. Specialty Matched Consultant Advisory Panel review 10/26/2016. No change to policy statement. (an)

11/10/17 Specialty Matched Consultant Advisory Panel review 10/25/2017. No change to policy statement. (an)

11/9/18 Minor formatting changes. Specialty Matched Consultant Advisory Panel review 10/24/2018. No change to policy statement. (an)

10/29/19 Specialty Matched Consultant Advisory Panel review 10/16/2019. No change to policy statement. (eel)

11/10/20 Specialty Matched Consultant Advisory Panel review 10/21/2020. No change to policy statement. (eel)

11/2/21 Specialty Matched Consultant Advisory Panel review 10/2021. Medical Director Review 10/2021. No change to policy statement. (tt)

11/1/22 Specialty Matched Consultant Advisory Panel review 10/2022. Medical Director Review 10/2022. No change to policy statement. (tt)

11/7/23 References updated. Removed D8690 from Billing/Coding section. Specialty Matched Consultant Advisory Panel review 10/2023. Medical Director Review 10/2023. No change to policy statement. (tt)